

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032924

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 332  
**FILED SEP 12 1963**

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		c. CITY OR TOWN <u>MONROE CITY</u>	
Length of stay in 1b <u>1 DAY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LEVERING HOSPITAL</u>		d. STREET ADDRESS <u>724 STANTON</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANNETTE</u> Middle <u>FRANCIS</u> Last <u>ELY</u>			4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>21</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 19, 1866</u>	9. AGE (last birthday) <u>97</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>NEW LONDON, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>WILLIAM B. STEVENS</u>			
13b. MOTHER'S MAIDEN NAME <u>BASSILLA PAYNE</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM I. ELY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Mrs. Lillian Crocker Monroe City Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter: nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		

21. I attended the deceased from 1960 to 1 Sept 1962 and last saw her alive on 9/1/62  
Death occurred at 11.20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wynne Hamlin M.P.</u>	(Degree or title)	22b. ADDRESS <u>Hannibal Mo</u>	22c. DATE SIGNED <u>9/4/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT 4, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST JUDES CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MONROE CITY, MISSOURI</u>

24. FUNERAL DIRECTOR <u>Wilson &amp; Sons</u>	ADDRESS <u>Monroe City Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 5, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Luche by Lillian M. Herman</u>
--	----------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

1 0648

2 0640

3

4 1

5 2

6

7 0

8 0

9 4200

10

11

12 1-0

13 1-0

NOT 1 1963

8620  
10190

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by me Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lester L. Hilkey

Licensed Embalmer No. 3014

P. O. Address Waco, Tex

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

Permit received 9/5/63